REFERENCE TITLE: insurance; claims; appeals; provider credentialing

State of Arizona
House of Representatives
Fifty-sixth Legislature
First Regular Session
2023

HB 2290

Introduced by
Representative Cook

AN ACT

AMENDING TITLE 20, CHAPTER 20, ARIZONA REVISED STATUTES, BY ADDING ARTICLE 3; AMENDING SECTIONS 20-3451, 20-3453 AND 20-3456, ARIZONA REVISED STATUTES; RELATING TO HEALTH INSURANCE.

(TEXT OF BILL BEGINS ON NEXT PAGE)

Be it enacted by the Legislature of the State of Arizona:

Section 1. Title 20, chapter 20, Arizona Revised Statutes, is amended by adding article 3, to read:

ARTICLE 3. DENIAL OF HEALTH CARE SERVICES CLAIMS

20-3121. Definitions

IN THIS ARTICLE, UNLESS THE CONTEXT OTHERWISE REQUIRES:

1. "CLAIM DISPUTE" MEANS A DISPUTE BETWEEN A HEALTH CARE INSURER AND A PROVIDER BASED ON THE HEALTH CARE INSURER'S:

(a) DENIAL OF A CLAIM, IN WHOLE OR IN PART.

(b) REDUCTION IN THE PAYMENT AMOUNT SOUGHT BY THE PROVIDER.

(c) FAILURE TO ADHERE TO THE TIME FRAMES PRESCRIBED IN THIS ARTICLE.

2. "DIRECTOR'S DECISION" MEANS FINAL ADMINISTRATIVE DECISION AS DEFINED IN SECTION 41-1092.

3. "HEALTH CARE INSURER" MEANS A DISABILITY INSURER, GROUP DISABILITY INSURER, BLANKET DISABILITY INSURER, HEALTH CARE SERVICES ORGANIZATION, HOSPITAL SERVICE CORPORATION, PREPAID DENTAL PLAN ORGANIZATION, MEDICAL SERVICE CORPORATION, DENTAL SERVICE CORPORATION OR OPTOMETRIC SERVICE CORPORATION.

4. "HEALTH CARE SERVICE":

(a) MEANS A HEALTH CARE PROCEDURE, TREATMENT OR SERVICE THAT IS COVERED BY A HEALTH CARE SERVICES PLAN.

(b) INCLUDES PRESCRIPTION DRUGS, DEVICES OR DURABLE MEDICAL EQUIPMENT THAT IS COVERED BY A HEALTH CARE SERVICES PLAN.

(c) DOES NOT INCLUDE TREATMENTS THAT ARE EXPERIMENTAL, INVESTIGATIONAL OR OFF LABEL.

5. "HEARING" MEANS AN ADMINISTRATIVE HEARING UNDER TITLE 41, CHAPTER 6, ARTICLE 10.

6. "PROVIDER" MEANS:

(a) A HEALTH PROFESSIONAL WHO IS LICENSED OR CERTIFIED PURSUANT TO TITLE 32, CHAPTER 7, 8, 11, 13, 15, 15.1, 16, 17, 18, 19, 19.1, 25, 28, 33, 34, 35 OR 39.

(b) A HEALTH CARE INSTITUTION AS DEFINED IN SECTION 36-401.

(c) ANY OTHER PERSON OR ENTITY THAT IS LICENSED OR OTHERWISE AUTHORIZED TO PROVIDE HEALTH CARE SERVICES IN THIS STATE.

20-3122. Denial of health care services claim; required information

IF A HEALTH CARE INSURER DENIES A HEALTH CARE SERVICES CLAIM, IN WHOLE OR IN PART, THE HEALTH CARE INSURER SHALL PROVIDE THE FOLLOWING INFORMATION TO THE PROVIDER:

1. AN EXPLANATION OF THE DENIAL. IF THE DENIAL IS BASED ON LACK OF MEDICAL NECESSITY, THE HEALTH CARE INSURER SHALL PROVIDE DETAILED INFORMATION AS TO WHY THE HEALTH CARE SERVICE WAS NOT MEDICALLY NECESSARY.

2. THE PROVIDER'S RIGHT TO APPEAL THE HEALTH CARE INSURER'S DECISION.

3. THE MANNER IN WHICH THE PROVIDER MAY APPEAL THE HEALTH CARE INSURER'S DECISION, INCLUDING APPLICABLE DEADLINES PRESCRIBED IN SECTION 20-3123.

4. THE PROVIDER'S RIGHT TO REQUEST A HEARING PURSUANT TO SECTION 20-3123 IF THE APPEAL TO THE HEALTH CARE INSURER IS UNSUCCESSFUL.

5. THE MANNER IN WHICH THE PROVIDER MAY REQUEST A HEARING.

20-3123. Claim disputes; hearing request; appeal

A. WITHIN ONE HUNDRED EIGHTY DAYS AFTER A PROVIDER RECEIVES NOTICE OF A HEALTH CARE INSURER'S DECISION TO DENY A CLAIM, THE PROVIDER MAY APPEAL THE DECISION AND FILE A WRITTEN CLAIM DISPUTE WITH THE HEALTH CARE INSURER. THE CLAIM DISPUTE SHALL SPECIFY THE FACTUAL BASIS FOR THE DISPUTE AND THE REQUESTED RELIEF.

B. WITHIN THIRTY DAYS AFTER RECEIVING THE WRITTEN CLAIM DISPUTE, THE HEALTH CARE INSURER SHALL RESPOND TO THE CLAIM DISPUTE IN WRITING WITH THE HEALTH CARE INSURER'S DECISION, UNLESS THE PROVIDER AND THE HEALTH CARE INSURER MUTUALLY AGREE TO A LONGER PERIOD OF TIME.

C. THE HEALTH CARE INSURER'S DECISION SHALL INCLUDE:

1. THE DATE OF THE DECISION.

2. THE FACTUAL AND LEGAL BASIS FOR THE DECISION.

3. THE PROVIDER'S RIGHT TO REQUEST A HEARING.

4. THE MANNER IN WHICH A PROVIDER MAY REQUEST A HEARING.

D. IF A CLAIM DISPUTE IS APPROVED, IN WHOLE OR IN PART, A HEALTH CARE INSURER SHALL REMIT PAYMENT FOR THE APPROVED PORTION OF THE CLAIM WITHIN FIFTEEN DAYS AFTER THE DATE OF THE HEALTH CARE INSURER'S DECISION.

E. IF A CLAIM DISPUTE IS DENIED, THE PROVIDER MAY SUBMIT A WRITTEN REQUEST FOR A HEARING TO THE DEPARTMENT WITHIN THIRTY DAYS AFTER RECEIVING THE HEALTH CARE INSURER'S DECISION OR THE DATE ON WHICH THE PROVIDER SHOULD HAVE RECEIVED THE HEALTH CARE INSURER'S DECISION AND SHALL SUBMIT A COPY OF THE HEARING REQUEST TO THE HEALTH CARE INSURER.

F. IF THE PROVIDER TIMELY SUBMITS A REQUEST FOR A HEARING WITH THE DEPARTMENT, THE DEPARTMENT SHALL REQUEST A HEARING WITH THE OFFICE OF ADMINISTRATIVE HEARINGS PURSUANT TO TITLE 41, CHAPTER 6, ARTICLE 10.

G. THE DEPARTMENT SHALL SEND THE DIRECTOR'S DECISION TO THE PROVIDER WITHIN THIRTY DAYS AFTER THE DATE THE ADMINISTRATIVE LAW JUDGE ISSUES ITS RECOMMENDED DECISION AND ORDER.

H. IF THE PROVIDER DECIDES TO WITHDRAW THE PROVIDER'S REQUEST FOR A HEARING, THE PROVIDER SHALL SEND A WRITTEN REQUEST FOR WITHDRAWAL TO THE DEPARTMENT. THE DEPARTMENT SHALL ACCEPT THE WRITTEN REQUEST FOR WITHDRAWAL IF THE WRITTEN REQUEST FOR WITHDRAWAL IS RECEIVED BEFORE THE DEPARTMENT REQUESTS A HEARING PURSUANT TO TITLE 41, CHAPTER 6, ARTICLE 10. IF THE DEPARTMENT ALREADY SUBMITTED A REQUEST FOR A HEARING, THE PROVIDER SHALL PROMPTLY SEND A WRITTEN REQUEST FOR WITHDRAWAL TO THE OFFICE OF ADMINISTRATIVE HEARINGS.

Sec. 2. Section 20-3451, Arizona Revised Statutes, is amended to read:

20-3451. Definitions

In this chapter, unless the context otherwise requires:

1. "Applicant" means a provider that submits a credentialing application to a health insurer to become a participating provider in the health insurer's network.

2. "Application" means an applicant's initial application to be credentialed as a participating provider.

3. "COMPLETE CREDENTIALING APPLICATION" MEANS SUBMISSION OF A HEALTH PLAN'S CREDENTIALING APPLICATION, INCLUDING ANY REQUIRED SUPPORTING DOCUMENTATION.

~~3.~~ 4. "Credentialing" means to collect, verify and assess whether a provider meets relevant licensing, education and training requirements to become or remain a participating provider.

~~4.~~ 5. "Designee" means a third party to whom the health insurer has delegated credentialing activities or responsibilities.

~~5.~~ 6. "Health insurer" means a disability insurer, group disability insurer, blanket disability insurer, health care services organization, hospital service corporation, medical service corporation or ~~a~~ hospital, medical, dental and optometric service corporation and includes the health insurer's designee. Health insurer does not include a pharmacy benefits manager as defined in section 20-3321.

~~6.~~ 7. "Loading" means to input a participating provider's information into a health insurer's billing system for the purpose of processing claims and submitting reimbursement for covered services.

~~7.~~ 8. "Participating provider" means a provider that has been credentialed by a health insurer ~~or its designee~~ to provide health care items or services to subscribers in at least one of the health insurer's provider networks.

~~8.~~ 9. "Provider" means a physician, hospital or other person that is licensed in this state or that is otherwise authorized to furnish health care services in this state.

~~9.~~ 10. "~~Recredentialing~~ RECREDENTIAL" means to confirm that a participating provider is in good standing by a health insurer ~~or its designee~~ and does not require submitting an application or going through a contracting and loading process.

~~10.~~ 11. "Subscriber" means a person who is eligible to receive health care benefits pursuant to a health insurance policy or coverage issued or provided by a health insurer.

Sec. 3. Section 20-3453, Arizona Revised Statutes, is amended to read:

20-3453. Credentialing; loading; timelines; exception

A. Except as provided in subsection C of this section, the health insurer shall conclude the process of credentialing and loading the

applicant's information into the health insurer's billing system within ~~one hundred~~ FORTY-FIVE calendar days after the date the health insurer receives a complete CREDENTIALING application.

B. A HEALTH INSURER SHALL PROVIDE WRITTEN OR ELECTRONIC CONFIRMATION:

1. WITHIN TWO BUSINESS DAYS ON RECEIPT OF A COMPLETE CREDENTIALING APPLICATION.

2. WITHIN SEVEN BUSINESS DAYS ON RECEIPT OF A CREDENTIALING APPLICATION WITH DEFICIENCIES.

~~B.~~ C. A health insurer shall provide written or electronic notice of the approval or denial of a COMPLETE credentialing application to an applicant within seven calendar days after the conclusion of the credentialing process.

~~C.~~ D. If a licensed health care facility has a delegated credentialing agreement with a health insurer, the health insurer is not responsible for compliance with the timeline prescribed in subsection A of this section for an applicant who works for that facility, but shall conclude the loading process for that applicant within ten calendar days after the health insurer receives a roster of demographic changes related to newly credentialed, terminated or suspended participating providers.

Sec. 4. Section 20-3456, Arizona Revised Statutes, is amended to read:

20-3456. Covered services; claims

A health insurer may not deny a claim for a covered service provided to a subscriber by a participating provider who has a fully executed contract with a network plan if the covered services are provided after the date of ~~approval~~ SUBMISSION of the COMPLETE credentialing application.